

**United States Department of Labor
Employees' Compensation Appeals Board**

V.L., Appellant

and

**U.S. POSTAL SERVICE, POST OFFICE,
Tampa, FL, Employer**

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**Docket No. 16-1558
Issued: April 4, 2017**

Appearances:

Denise Prado, for the appellant¹

Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:

CHRISTOPHER J. GODFREY, Chief Judge

COLLEEN DUFFY KIKO, Judge

ALEC J. KOROMILAS, Alternate Judge

JURISDICTION

On July 27, 2016 appellant, through her representative, filed a timely appeal of a May 26, 2016 merit decision and a June 16, 2016 nonmerit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act² (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

¹ In all cases in which a representative has been authorized in a matter before the Board, no claim for a fee for legal or other service performed on appeal before the Board is valid unless approved by the Board. 20 C.F.R. § 501.9(e). No contract for a stipulated fee or on a contingent fee basis will be approved by the Board. *Id.* An attorney or representative's collection of a fee without the Board's approval may constitute a misdemeanor, subject to fine or imprisonment for up to one year or both. *Id.*; *see also* 18 U.S.C. § 292. Demands for payment of fees to a representative, prior to approval by the Board, may be reported to appropriate authorities for investigation.

² 5 U.S.C. § 8101 *et seq.*

ISSUES

The issues are: (1) whether appellant has met her burden of proof to establish more than 10 percent permanent impairment of her left upper extremity for which she previously received schedule awards; and (2) whether OWCP properly denied appellant's request for reconsideration on the merits pursuant to 5 U.S.C. § 8128(a).

FACTUAL HISTORY

On April 4, 2006 appellant, then a 40-year-old mail carrier, filed a recurrence claim (Form CA-2a) alleging a recurrence of her medical condition on September 28, 2006 due to her March 1, 1999 employment injury.³ OWCP developed this as a new occupational disease claim. Appellant alleged that she had received continued medical treatment for her March 1, 1999 employment injury. The employing establishment noted that she had returned to full duty on April 19, 2000. Appellant accepted a light-duty assignment at the employing establishment on June 10, 2006.

In a report dated February 19, 2007, Dr. Roanna Garner, a Board-certified neurologist, reviewed appellant's diagnostic studies, including magnetic resonance imaging (MRI) scans dated January 13 and November 14, 2005, and found that appellant's left rotator cuff was intact with mild tendinosis of the supraspinatus tendon. She diagnosed chronic cervical sprain, left shoulder injury, and left elbow tendinitis. Dr. Garner opined that appellant had 20 percent joint impairment, 5 percent upper extremity impairment of the left shoulder, and 5 percent cervical spine impairment. She issued a similar report on July 26, 2007.

Appellant filed a schedule award claim (Form CA-7) on August 17, 2007. OWCP's medical adviser reviewed Dr. Garner's reports and determined that appellant had no ratable permanent impairment of her left arm pursuant to the American Medical Association, *Guides to the Evaluation of Permanent Impairment*⁴ (A.M.A., *Guides*).

In a decision dated December 11, 2007, OWCP denied appellant's request for a schedule award finding that the medical evidence failed to establish a permanent measurable scheduled impairment.

Appellant underwent an additional left shoulder MRI scan on March 5, 2012 which demonstrated impingement and heterogeneous signals in the supraspinatus and infraspinatus tendons. She underwent a cervical MRI scan on August 1, 2012 which indicated mild diffuse asymmetrical disc bulges and posterocentral disc protrusions at C3-4 through C6-7 levels with straightening of the cervical lordosis, suggestive of paraspinal muscle spasm. Appellant

³ OWCP had accepted appellant's claim for cervical sprain and aggravation of left shoulder tendinitis on June 21, 2006.

⁴ At the time of this report, OWCP relied on the fifth edition of the A.M.A., *Guides* to determine permanent impairment for schedule award purposes. A.M.A., *Guides*, (5th ed. 2001). For new decisions issued after May 1, 2009 OWCP began using the sixth edition of the A.M.A., *Guides*. A.M.A., *Guides*, (6th ed. 2009); Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Award and Permanent Disability Claims*, Chapter 2.808.5a (February 2013); *id.* Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010).

underwent a nerve conduction velocity study on April 3, 2013 which was read as abnormal and indicative of a right C6 upper trunk entrapment.

Appellant's attending physician, Dr. Samy F. Bishai, an orthopedic surgeon, completed a report on February 11, 2014 and opined that appellant had reached maximum medical improvement. He noted that her left shoulder was tender overlying the anterior, lateral, and posterior aspects of the shoulder joint. Dr. Bishai used the range of motion (ROM) method of rating permanent impairment and found 80 degrees of flexion, 20 degrees of extension, 80 degrees of abduction, 15 degrees of adduction, 50 degrees of external rotation, and 40 degrees of internal rotation. He found reduced sensation in the ulnar nerve distribution of the left hand with a positive Tinel's sign and a positive Phalen's test. Dr. Bishai diagnosed chronic cervical strain, cervical disc syndrome, internal derangement of the left shoulder, radiculopathy of the upper extremities bilaterally, carpal tunnel syndrome of the left hand, and left shoulder impingement syndrome. He opined that appellant's left shoulder should be evaluated for permanent impairment purposes based on her loss of ROM. Dr. Bishai referenced Table 15-34 of the A.M.A., *Guides*⁵ and found that 80 degrees of flexion was nine percent permanent impairment, that 20 degrees of extension was two percent permanent impairment, that 80 degrees of abduction was six percent permanent impairment, that 15 degrees of adduction was one percent permanent impairment, that 20 degrees of internal rotation was four percent permanent impairment, and that 50 degrees of external rotation was two percent permanent impairment. Dr. Bishai concluded that appellant had 24 percent permanent impairment of her left arm using the ROM method.

Appellant again, on April 1, 2014, filed a claim for a schedule award (Form CA-7).

In a decision dated April 8, 2014, OWCP accepted the additional conditions of sprain of the neck, calcifying tendinitis of the left shoulder, and aggravation of displacement of cervical disc without myelopathy.

OWCP requested additional medical evidence on April 28, 2014 to support appellant's permanent impairment claim for schedule award purposes. It afforded her 30 days to respond.

Appellant underwent a cervical MRI scan on April 17, 2014 which demonstrated disc bulge at C4-5 which indented the anterior thecal sac, disc herniation at C5-6, as well as disc bulge, and herniation at C6-7.

Dr. Harvey Bishow, a Board-certified orthopedic surgeon, examined appellant on May 19, 2014 also used the ROM method of rating permanent impairment. He found 160 degrees of abduction, 130 degrees of flexion, 60 degrees of internal rotation, and normal external rotation. Dr. Bishow noted that appellant had requested a surgical evaluation of her left shoulder. He then provided an impairment rating based on both her loss of ROM in the left shoulder as well as a rating using the diagnosis-based impairment (DBI) method of impairment rating for a partial rotator cuff tear. Dr. Bishow combined these impairment ratings to reach 13 percent permanent impairment of the left upper extremity.

⁵ A.M.A., *Guides* 475, Table 15-34.

OWCP's medical adviser reviewed Dr. Bishow's report and determined that appellant was not entitled to a permanent impairment rating based on both DBI and ROM. He reviewed her ROM examination findings and found that under Table 15-34⁶ that she had eight percent permanent impairment of her left upper extremity.

By decision dated June 26, 2014, OWCP granted appellant a schedule award for eight percent permanent impairment of her left upper extremity. Appellant disagreed with this decision and requested an oral hearing with a representative of OWCP's Branch of Hearings and Review on July 3, 2014.

On February 11, 2015 at the oral hearing before an OWCP hearing representative, appellant's representative contended that OWCP's medical adviser improperly discounted Dr. Bishai's report and also improperly reduced Dr. Bishow's impairment rating.

By decision dated April 30, 2015, OWCP's hearing representative set aside OWCP's June 26, 2014 schedule award determination and remanded the case for referral to a second opinion physician to determine which of appellant's left shoulder conditions were related to her employment and whether she had any permanent impairment of the left upper extremity warranting a schedule award.

OWCP developed a statement of accepted facts on May 11, 2015 which listed the accepted conditions as neck sprain, aggravation of left shoulder tendinitis, and aggravation of displacement of cervical disc without myelopathy. It noted that appellant had three additional claims, File No. xxxxxx171 under which OWCP accepted neck and left trapezius injuries, File No. xxxxxx076 under which OWCP accepted lumbar and cervical strains, and File No. xxxxxx535 under which OWCP accepted adhesive capsulitis of the right shoulder.

On May 18, 2015 OWCP referred appellant for a second opinion evaluation, with Dr. William Dinenberg, a Board-certified orthopedic surgeon, to determine the extent of her permanent impairment for schedule award purposes. Dr. Dinenberg completed a report on June 9, 2015. He described appellant's history of injury and noted that she was currently working full-time light-duty. Dr. Dinenberg reviewed her medical history and diagnostic studies. He performed a physical examination and found left shoulder ROM at 120 degrees of flexion, 50 degrees of extension, 20 degrees of internal rotation, 70 degrees of external rotation, 90 degrees of abduction, and 40 degrees of adduction. Dr. Dinenberg noted that appellant had a positive impingement sign with normal muscle strength and no acromioclavicular (AC) joint pain to palpation. He reported that she had positive Phalen's test, positive Tinel's sign, and positive carpal tunnel compression test at the left wrist. Dr. Dinenberg found decreased sensation to light touch in the left small finger, ring finger, and thumb. He diagnosed aggravation of left shoulder tendinitis, and sprain of the cervical spine with aggravation of cervical disc displacement without myelopathy. Dr. Dinenberg used the ROM method and correlated appellant's left shoulder loss of ROM with the A.M.A., *Guides*⁷ and found that she had 3 percent permanent impairment due to 120 degrees of flexion, 4 percent permanent

⁶ *Id.*

⁷ *Id.*

impairment due to 20 degrees of internal rotation, and 3 percent permanent impairment due to 90 degrees of abduction for a total permanent impairment rating of 10 percent of the left upper extremity.

OWCP's medical adviser reviewed the medical evidence of record on July 24, 2015 and found that Dr. Dinenberg's report established appellant's permanent impairment for schedule award purposes at 10 percent of the left upper extremity due to loss of ROM.

By decision dated July 28, 2015, OWCP granted appellant a schedule award for an additional two percent permanent impairment of her left upper extremity. On August 5, 2015 appellant disagreed with this decision and requested an oral hearing.

Appellant testified at the oral hearing on March 15, 2016 before an OWCP hearing representative. Appellant's representative contended that Dr. Bishai's impairment rating was the most appropriate.

On April 7, 2016 appellant underwent a left shoulder MRI scan which demonstrated rotator cuff tendinosis with a partial thickness tear of the supraspinatus tendon and a partial thickness tear of the infraspinatus tendon. This MRI scan also demonstrated mild chronic AC joint osteoarthritis and mild bursitis.

Appellant submitted a report from Dr. Bishai completed on July 4, 2015. In his examination of her left shoulder, Dr. Bishai found loss of ROM including forward elevation of 75 degrees, backward elevation of 15 degrees, abduction of 75 degrees, adduction of 15 degrees, external rotation of 40 degrees, and internal rotation of 20 degrees. He found electrodiagnostic evidence consistent with cervical radiculopathy affecting the upper extremities. Dr. Bishai diagnosed chronic cervical strain, cervical disc syndrome, internal derangement of the left shoulder, bilateral radiculopathy of the upper extremities, left carpal tunnel syndrome, and left shoulder impingement syndrome. He reviewed Dr. Dinenberg's report and disagreed with his findings of appellant's ROM. Dr. Bishai noted, "I have seen [appellant] numerous times and I conducted this examination many times and the [ROM] figures have remained very close every time I do the examination, so my impairment rating is based on multiple visits and many [ROM] examinations at different times." He opined that Dr. Dinenberg's examination was very brief and that he did not "do much" of a complete examination in every movement.

By decision dated May 26, 2016, OWCP's hearing representative found that appellant had not established more than 10 percent permanent impairment of her left upper extremity entitling her to a schedule award. She found that Dr. Dinenberg's impairment rating based on his ROM figures was appropriate.

Appellant's representative again requested reconsideration of the May 26, 2016 decision and alleged an unresolved conflict of medical opinion evidence between appellant's physician and OWCP's medical adviser.

In a decision dated June 16, 2016, OWCP declined to reopen appellant's claim for consideration of the merits as no additional factual or medical evidence was submitted in support of her request for reconsideration.

LEGAL PRECEDENT -- ISSUE 1

Section 8149 of FECA delegates to the Secretary of Labor the authority to prescribe rules and regulations for the administration and enforcement of FECA. The Secretary of Labor has vested the authority to implement the FECA program with the Director of OWCP.⁸ Section 8107 of FECA sets forth the number of weeks of compensation to be paid for the permanent loss of use of specified members, functions, and organs of the body.⁹ FECA, however, does not specify the manner by which the percentage loss of a member, function, or organ shall be determined. To ensure consistent results and equal justice under the law, good administrative practice requires the use of uniform standards applicable to all claimants. Through its implementing regulations, OWCP adopted the A.M.A., *Guides* as the appropriate standard for evaluating schedule losses.¹⁰

The sixth edition of the A.M.A., *Guides* was first printed in 2008. Within months of the initial printing, the A.M.A. issued a 52-page document entitled “Clarifications and Corrections, Sixth Edition, *Guides to the Evaluation of Permanent Impairment*.” The document included various changes to the original text, intended to serve as an *erratum*/supplement to the first printing of the A.M.A., *Guides*. In April 2009, these changes were formally incorporated into the second printing of the sixth edition.

As of May 1, 2009, schedule awards are determined in accordance with the sixth edition of the A.M.A., *Guides* (2009).¹¹ The Board has approved the use by OWCP of the A.M.A., *Guides* for the purpose of determining the percentage loss of use of a member of the body for schedule award purposes.¹²

ANALYSIS -- ISSUE 1

The issues on appeal are whether appellant has met her burden of proof to establish more than 10 percent permanent impairment of her left upper extremity for which she has previously received a schedule award and whether OWCP properly denied her request for reconsideration on the merits pursuant to 5 U.S.C. § 8128(a).

The Board finds that this case is not in posture for decision.

The Board has found that OWCP has inconsistently applied Chapter 15 of the sixth edition of the A.M.A., *Guides* when granting schedule awards for upper extremity claims. No

⁸ See 20 C.F.R. §§ 1.1-1.4.

⁹ For a complete loss of use of an arm, an employee shall receive 312 weeks’ compensation. 5 U.S.C. § 8107(c)(1).

¹⁰ 20 C.F.R. § 10.404. See also *Ronald R. Kraynak*, 53 ECAB 130 (2001).

¹¹ See Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010); Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5a (February 2013).

¹² *Isidoro Rivera*, 12 ECAB 348 (1961).

consistent interpretation has been followed regarding the proper use of the DBI or the ROM methodology when assessing the extent of permanent impairment for schedule award purposes.¹³ The purpose of the use of uniform standards is to ensure consistent results and to ensure equal justice under the law to all claimants.¹⁴ In *T.H.*, the Board concluded that OWCP physicians are at odds over the proper methodology for rating upper extremity impairment, having observed attending physicians, evaluating physicians, second opinion physicians, impartial medical examiners, and district medical advisers use both DBI and ROM methodologies interchangeably without any consistent basis. Furthermore, the Board has observed that physicians interchangeably cite to language in the first printing or the second printing when justifying use of either ROM or DBI methodology. Because OWCP's own physicians are inconsistent in the application of the A.M.A., *Guides*, the Board finds that OWCP can no longer ensure consistent results and equal justice under the law for all claimants.¹⁵

In light of the conflicting interpretation by OWCP of the sixth edition with respect to upper extremity impairment ratings, it is incumbent upon OWCP, through its implementing regulations and/or internal procedures, to establish a consistent method for rating upper extremity impairment. In order to ensure consistent results and equal justice under the law for cases involving upper extremity impairment, the Board will set aside the May 26 and June 16, 2016 decisions.¹⁶ Following OWCP's development of a consistent method for calculating permanent impairment for upper extremities to be applied uniformly, and such other development as may be deemed necessary, OWCP shall issue a *de novo* decision on appellant's claim for an upper extremity schedule award.

CONCLUSION

The Board finds this case not in posture for decision.

¹³ *T.H.*, Docket No. 14-0943 (issued November 25, 2016).

¹⁴ *Ausbon N. Johnson*, 50 ECAB 304, 311 (1999).

¹⁵ *Supra* note 12.

¹⁶ Due to the outcome of issue 1, the issue of whether OWCP properly denied appellant's request for reconsideration of the merits of her claim is moot.

ORDER

IT IS HEREBY ORDERED THAT the May 26 and June 16, 2016 decisions of the Office of Workers' Compensation Programs are set aside, and the case is remanded for further action consistent with this decision.

Issued: April 4, 2017
Washington, DC

Christopher J. Godfrey, Chief Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

Alec J. Koromilas, Alternate Judge
Employees' Compensation Appeals Board